2007

Medical Plan

Information

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Employee	$526	$508	$438	$418
Employee & spouse	$698	$668	$586	$564
Employee & children	$652	$626	$550	$528
Employee & family	$726	$696	$610	$586
Joint Core	$580	$548	$476	$454

MEDICAL PLAN COSTS

Annual Deductible*
(Applies to all services, unless otherwise noted or a co-payment is indicated)

Coinsurance Percentages (% of allowed charges that the member pays)
General
Preferred Facility Services *(See page 34 & 35 for a list of preferred facilities)*
Nonpreferred Facility Services *(See page 34 & 35 for a list of non-preferred facilities)*

Annual Out-of-Pocket Maximums*
(Maximum coinsurance paid in the year; excludes deductibles and copayments)

MEDICAL PLAN SERVICES

Hospital Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Room Charges

Ancillary Services

Surgical Services

Outpatient Services

BENEFIT YEAR 2007

MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maximum payable per person, per lifetime on the Plan. The amounts shown below are the amounts that the plan would pay per individual.

Traditional Plan: $1,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

Managed Care Plans: $1,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

TRADITIONAL PLAN	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Administered by BCBS	In-Network Benefits	Out-of-Network Benefits
$550/Member $1,650/Family	$400/Member $800/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
***You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).**		
Coinsurance:	Coinsurance/Copayment:	Coinsurance:
20% - 35%	25%	35%
20% - 25%	25%	35%
20% - 25%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Physician Services

Office Visits

Inpatient Physician Services

Lab/Ancillary/Miscellaneous Charges

Allergy Shots

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room

Hospital Charges

Professional Charges

Urgent Care Services

Facility/Professional Charges

Lab & Diagnostic Charges

Maternity Services

Hospital Charges

Physician Charges

Prenatal Office Visits

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services

Adult Exams and Tests
Mammogram, gyno exam and pap, proctoscopic and colonoscopic exams, PSA tests, bone density tests

Adult Immunizations (Pneumonia and Flu)

Child Checkups and Immunizations

Mental Health Services

Inpatient Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)
Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

BENEFIT YEAR 2007

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	$15/visit (no deductible (only includes basic preventive labs)	35%
25%	25%	35%
25%	25%	35%
25% (no deductible)	$15/visit	35%
25%	$100 copay	$100 copay
20%-35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	$75/visit for facility charges only
25%	25%	25%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	25%	35%
25%	$50 global copay for **routine office visits**	35%
20% - 35% (no deductible)	25%	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $500 for colonoscopy, sigmoidoscopy, or proctoscopy	$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and other limited lab work) $0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35% (plan pays $75.00 toward mammograms - no deductible)
$50 Max (no deductible)	$15 with office visit 25% (no deductible) without office visit	35%
25% (no deductible) 0% (no deductible for County Health Department through age 5)	$15/visit **Max**: Academy of Pediatrics Definitions *(through age 18)*	35%
20% - 35% 21 days *(No max for severe conditions)*	25% 21 days *(No max for severe conditions)*	35% 21 days *(No max for severe conditions)*
25% **Max**: 40 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35% **Max**: 30 visits *(No max for severe conditions)*
50% **Max**: 20 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35% **Max**: 30 visits *(No max for severe conditions)*

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Chemical Dependency

Inpatient Services*
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services*
With EAP counselor referral

With NO EAP counselor referral

*Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

Rehabilitative Services

Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy

Inpatient Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services *(Physician ordered/prior authorization recommended)*

Home Health Care

Hospice

Skilled Nursing

Miscellaneous Services

Dietary/Nutritional Counseling
(When medically necessary and physician ordered)

Durable Medical Equipment, Appliances, and Orthotics
(Prior authorization required for amounts over $1,000)

PKU Supplies

Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*

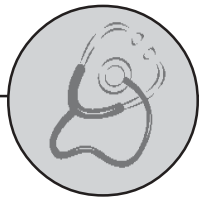
Transplant Services

Lifetime Maximums:

BENEFIT YEAR 2007

	TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
	20% - 35%	25%	35%
	25% **Max**: 40 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35% **Max**: Dollar Limit*
	50% **Max**: 20 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35% **Max**: Dollar Limit*
	20% - 35% **Max**: 60 days	25% **Max**: 60 days	35% **Max**: 60 days
	20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit)	Not covered	Not covered
	25% (plus charges over $30/visit) **Max**: 25 visits in any combination	$15/visit **Max**: 20 visits	35% **Max:** 20 visits
	25% **Max**: 70 days	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
	25% (20% - 35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
	25% (20% - 35% if hospital-based) **Max**: 70 days	25% **Max**: 30 days	35% **Max**: 30 days
	20% - 35% **Max**: $250	$15/visit	35%
	25% **Max**: $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35% **Max**: $100 for foot orthotics (per foot)
	25%	Plan pays for 100% for services	35%
	25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE PLANS - 2007



Administered by:
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WHO IS ELIGIBLE?

Employees, spouses, domestic partners, and children are eligible for the Medical Insurance Plan. Enrollment is only allowed during these circumstances:

- within a new employee's initial 31-day enrollment period;
- within 63 days of becoming a dependent (through marriage, birth, adoption, pre-adoption, or court-ordered custody/legal guardianship);
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits.

Notify your Agency Insurance Personnel when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

CLICK ON IT!

Learn more about your insurance administrator's customer service by visiting their web site at:

www.bluecrossmontana.com

www.newwesthealth.com

www.healthinfonetmt.com

INSTRUCTIONS

1. Read about each plan in the General Information section on this page.
2. Review and compare each plans' costs and services in the Benefits Summary, starting on page 6.
3. Review your typical health care needs.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 31 through 33.
5. Determine which plan will work best for your family. Make your selection by completing the Enrollment/Change form.

Employee Group Benefits Enrollment/Change Form

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice**
- **New West Health Plan**
- **Peak Health Plan**

TRADITIONAL PLAN

The Traditional Indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. **Please verify a provider is currently participating by calling BCBS or checking their website.**

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 34 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West, and Peak Health are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral/authorization is obtained).

In-Network Benefits

Anytime a network provider is used whether the provider is a general practitioner, internist, or specialist, the in-network (highest level of benefit) is applied.

Check the plan's website for a complete listing of all in-network providers. A referral/authorization is not required for in-network specialists. Referrals/authorizations are required to see an out-of-network specialist to receive the in-network level of benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, with no required referral/authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 31-33 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana and many other towns including Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Billings, Great Falls, Havre, Libby, and Miles City.

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and the surrounding communities.

IMPORTANT!
BCBS providers for the Traditional plan are different than the BCBS providers for the Blue Choice plan. A provider may be a member provider on one or both plans.

WORKING FAMILIES TAX RELIEF ACT (WFTRA)

WFTRA DEFINED

The Working Families Tax Relief Act is an IRS regulation that requires employees who cover dependents on their medical, dental, or vision coverage certify the tax status of each dependent. This certification is done at the time of enrollment included on the *Group Enrollment/Change* form.

WHO IS AFFECTED

All employees who cover dependents on medical, dental, or vision coverage.

REQUIRED DOCUMENTATION

New employees who decide to elect coverage for dependents must complete the section of the *Group Enrollment / Change* form indicating whether each depending (spouse, domestic partner, children) is or is not qualified for tax purposes. **This form must be completed and returned to the Health Care and Benefits Division along with your other election forms within 31 days of hire** for the appropriate tax application of benefits.

COMPLETING THE FORM

To assist in completing this form, flow charts (spouse, child, domestic partner) outlining the IRS rules applicable to each of your dependents are also provided for you with this packet.

TAX CONSEQUENCES

If you return the form indicating that all your dependents are tax qualified, your premiums are eligilble for a pre-tax deduction.

If you return the form indicating that all or some of your dependents are NOT tax qualified, premium contributions for those persons cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (*i.e.*, those benefits funded through the state share) for these persons will be added to your taxable income.

If the form is not returned, premium contributions for dependents cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (*i.e.*, those benefits funded through the state share) for these persons will be added to your taxable income until such time as the return of the form indicates otherwise. In this case, changes can only be made prospectively.